

**OEAP Participation Agreement
Authorization for Release of Information
Management/Union**

I, _____ of _____
(Name of Client/Participant) (Client's Address)

authorize **THE OHIO EMPLOYEE ASSISTANCE PROGRAM** to disclose to agency **Management or**

Union Representative: Management _____
(Name of Person)

Union _____
(Name of Person)

Management _____
(Complete mailing address including zip code) (Phone number)

Union _____
(Complete mailing address including zip code) (Phone number)

the following information: **EMPLOYEE PARTICIPATION IN THE OEAP.**

This disclosure is made for the following reason (s): TO DETERMINE CONTINUED EAP PARTICIPATION AND BACK UP DOCUMENTATION OF THE EFFORT TO SUSPEND DISCIPLINE WHILE SEEKING ASSISTANCE.

Specific information to be disclosed: VERIFICATION OF EMPLOYEE KEEPING SCHEDULED APPOINTMENTS, GENERAL MEASURE OF EMPLOYEE COMPLIANCE WITH RECOMMENDED COURSE(S) OF ACTION TOWARD RESOLVING PERSONAL ADJUSTMENT PROBLEMS CONTRIBUTING TO JOB PERFORMANCE PROBLEMS.

This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

This consent (unless expressly revoked earlier) expires upon _____ or six months
from date of signature. (Date of PA expiration)

(Signature of Client/Participant) (Date)

(Date of Birth) (Social Security Number)

(Signature of Legal Guardian, if Applicable)

(Witness)

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) and Sec. 3701.041 of the Ohio Revised Code and HIPPA standards prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Revised 09.19.14